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STATE OF NEW JERSEY
DEPARTMENT OF LAW & PUBLIC SAFETY
DIVISION OF CONSUMER AFFAIRS
STATE BOARD OF MEDICAL EXAMINERS

IN THE MATTER OF VINCENT JOSEPH THOMPSON, M.D. License No. MA77934 TO PRACTICE MEDICINE AND SURGERY IN THE STATE OF NEW JERSEY	Administrative Action CONSENT ORDER

THIS MATTER was opened to the New Jersey State Board of Medical Examiners ("Board") upon receipt of information that on or about May 15, 2006 the Oregon Board of Medical Examiners and Vincent Joseph Thompson, M.D. ("Respondent") entered into a Stipulated order ("Exhibit A"). In the Stipulated Order, the Respondent admitted to unprofessional or dishonorable conduct;

gross or repeated acts of negligence; and prescribing controlled substances without following accepted procedures for examining patients, record keeping, or giving the required notice.

As a result of the foregoing, the Respondent was placed on probation for five years, and should Respondent engage in the practice of medicine in Oregon, then he must report to the Board at each of its quarterly meetings for a probationer interview. Further, Respondent was required to enroll in a structured physician's education program with ongoing monitoring of his practice to address the areas of need identified in the CPEP evaluation report ("Exhibit B"), which must be completed within 24 months of the Stipulated Order.

As a result of the foregoing, the Board has determined that Respondent's acts giving rise to the Stipulated Order entered by the Oregon Board of Medical Examiners provides a basis for disciplinary action pursuant to N.J.S.A. 45:1-21(c) and N.J.S.A. 45:1-21(d).

IT NOW APPEARING that the parties wish to resolve this matter without recourse to formal proceedings; and that the Respondent hereby waives any right to a hearing in this matter; and the Board finding the within Order adequately protects the public's health, safety and welfare; and for good cause shown;

IT IS ON THIS 8th day of August, 2007, **ORDERED AND AGREED THAT:**

1. Respondent shall be, and hereby is, placed on a period of probation for five (5) years effective from the filing date of this Consent Order;

2. Respondent shall comply with all recommendations set forth in the CPEP evaluation performed on August 4 and 5, 2005, including completion of a remedial education and proctoring program pre-approved by the Board, within twenty four (24) months of the filing date of this Consent Order;

3. Upon successful completion of the remedial education and proctoring program, Respondent must immediately undergo a Board-approved CPEP evaluation, or an equivalent Board-approved reassessment program, to evaluate whether Respondent has remediated the issues outlined in the CPEP evaluation performed on August 4 and 5, 2005;

4. Upon successful completion of a Board-approved CPEP evaluation, or equivalent Board-approved reassessment program, Respondent shall be required to appear before the Board or a Committee thereof to demonstrate: (1) fitness to practice; (2) that he has fully complied with this Consent Order; and (3) that he has complied with the Stipulated Order issued by the Oregon Board of Medical Examiners. Additionally, the Board reserves the right to place restrictions and/or limitations upon Respondent's license to practice in the State of New Jersey; and

5. Respondent agrees that if the Board, at its sole discretion, determines that the Respondent has failed to comply with any provision of this Consent Order, then Respondent's New Jersey license to practice medicine and surgery shall be immediately suspended. Within ten (10) days of notification of the suspension, Respondent may seek a hearing before a Committee of the Board limited to the sole issue of violation of this Consent Order.

STATE BOARD OF MEDICAL EXAMINERS

By: _____ V.P. Board

Karen Criss, RN, CNM
Board Vice President

I have read and I understand this Consent Order and agree to be bound by its terms. I further hereby consent to the entry of this Consent Order.

_____

VINCENT JOSEPH THOMPSON, M.D.

BEFORE THE

BOARD OF MEDICAL EXAMINERS

STATE OF OREGON

In the Matter of VINCENT JOSEPH THOMPSON, MD LICENSE NO. MD 24259	)	STIPULATED ORDER

1.

The Board of Medical Examiners (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including physicians, in the state of Oregon. Joseph Vincent Thompson, MD (Licensee) is a licensed physician in the state of Oregon.

2.

The Board proposed taking disciplinary action pursuant to ORS 677.205 against Licensee for violations of the Medical Practice Act, to wit: ORS 677.190(1)(a) unprofessional or dishonorable conduct, as defined in ORS 677.188(4)(a); ORS 677.190(14) gross or repeated acts of negligence; and ORS 677.190(25) prescribing controlled substances without following accepted procedures for examining patients, record keeping, or giving the notice required under ORS 677.485. The Board concludes that Licensee engaged in the following conduct:

2.1 Review of Licensee's management of patients revealed the following pattern in regard to Patients A - E: Licensee failed to document any PARQ conference (procedures, alternatives, risks, and questions by patient, or PARQ discussion) in order to obtain their informed consent. Licensee's charting was deficient, lacking objective findings to justify the need for chronic pain medications. The patient histories, physical examinations and patient conditions that Licensee documented do not justify his assessments and plans for treatment, and he failed to address drug interactions, risks associated with medications prescribed, or

EXHIBIT A

utilize pain contracts. In addition to this conduct, which is common for Patients A - E, the Board identified the following specific concerns in regard to the patients listed below:

a. Patient A, a 42-year-old female, with a history of drug seeking behavior, first presented to Licensee in September 2003 with complaints of pain associated with torn ligaments (probable medial meniscal tear) in her right knee and lower back pain. Licensee authorized refills for prescriptions for paroxetine (Paxil), hydrocodone/-acetaminophen (Schedule III) and lorazepam (Ativan, Schedule IV) during her successive visits to the clinic. Patient A was supposed to return to the clinic every month, but was noncompliant, and was occasionally angry and belligerent. Licensee subsequently continued to prescribe hydrocodone/acetaminophen (Schedule III) for Patient A on a monthly basis. In April 2004, Licensee noted that Patient A was also taking warfarin (Coumadin), and had a diagnosis of atrial fibrillation. There is no indication that Licensee considered the risks associated with the concurrent administration of these medications, nor did he inform Patient A of the risk of adverse drug interactions. It is not clear from the record who was providing or monitoring this patient's warfarin. Throughout his care for Patient A, Licensee never utilized a written pain contract to verify compliance with her prescription regimen. Licensee last saw Patient A on June 2, 2004. She died from a drug overdose on July 2, 2004.

b. Patient B, a 42-year-old female, first presented to Licensee on June 19, 2003. Licensee authorized refills of her regimen of medications, to include temazepam (Restoril, Schedule IV), hydrocodone/acetaminophen, 10/650 (Schedule III), methocarbamol (Robaxin), 75 mgs twice a day, citalopram (Celexa) and captopril (Capoten). Patient B was also using fentanyl (Duragesic patches, Schedule II) for a herniated disc and fibromyalgia. By mid summer of 2003, Patient B had discontinued taking fentanyl, and was now taking morphine sulphate (MS Contin, Schedule II) while her prescription for hydrocodone/acetaminophen, 10/650 was increased to two tablets, four times a day (equalling an intake of 5.2 grams of acetaminophen per day,

which is a toxic dose level). Licensee prescribed indomethacin (Indocin) on March 12, 2004. Patient B reported stomach pain and nausea on March 31, 2004. On May 17, 2004, Patient B reported severe pain and vomiting all of her medications. Licensee examined her, but made very limited physical findings. Licensee also resumed her prescription for fentanyl (Duragesic patches, Schedule II), and changed her other medications from oral to transdermal and suppositories. Patient B was admitted to the Seaside Providence Emergency Room between May 17, 2003 and May 23, 2004 for a perforated bowel. Licensee failed to adequately examine and work up Patient B, and failed to provide her with a written notice of the material risks associated with the controlled substances that Licensee prescribed for chronic pain.

c. Licensee first saw Patient C, a 48-year-old female, on July 18, 2003. Licensee diagnosed her condition as a back disorder unspecified. Licensee continued her prescriptions of hydrocodone/acetaminophen (Schedule III) and zolpidem (Ambien, Schedule IV). Licensee failed to provide written notice of the material risks associated with the controlled substances that Licensee prescribed for chronic pain.

d. Patient D, a 43-year-old female, first presented to Licensee on June 25, 2003 with a complaint regarding a kidney stone. Licensee examined her, recorded a history and physical, and prescribed trimethoprim/sulfamethoxazole (Bactrim). On May 26, 2004, Patient D reported a severe outbreak of psoriasis on the "lower extremities." Licensee prescribed methotrexate, 12 mg, with six weekly injections without adequate medical justification. Licensee did not record any warning to this patient of the risks associated with this medication, to include toxicity to the liver, and failed to conduct any tests, to include liver function studies, either at the outset or during the course of this medication regimen.

e. Patient E, a 63-year-old male, presented to Licensee on November 13, 2003 complaining of patches of psoriasis. Licensee started Patient E on methotrexate. Licensee did not record any warning to this patient of the risks associated with this

medication, to include toxicity to the liver, and failed to conduct any tests, to include liver function studies, either at the outset or during the course of this medication regimen.

2.2 Licensee underwent a Board ordered assessment at the Center for Personalized Education for Physicians (CPEP). This evaluation concluded that Licensee possessed broad but superficial knowledge of outpatient family medicine, with gaps in his knowledge regarding pharmacology. Licensee is also deficient in his knowledge of certain serious health conditions, clinical reasoning and charting.

3.

Licensee and the Board desire to settle this matter by entry of this stipulated order. Licensee understands that he has the right to a contested case hearing under the Administrative Procedures Act (chapter 183), Oregon Revised Statutes, and fully and finally waives the right to a contested case hearing and any appeal therefrom by the signing of and entry of this Order in the Board's records. Licensee admits that he engaged in the conduct described in paragraph 2 and that this conduct violated ORS 677.190(1)(a) unprofessional or dishonorable conduct, as defined in ORS 677.188(4)(a); ORS 677.190(14) gross or repeated acts of negligence; and ORS 677.190(25) prescribing controlled substances without following accepted procedures for examining patients, record keeping, or giving the notice required under ORS 677.485. Licensee understands that this Order is a public record and is reportable to the National Practitioner Databank.

4.

Licensee and the Board desire to settle this matter by the entry of this Stipulated Order, subject to the following terms and conditions of probation:

4.1 Licensee is placed on probation for five years. Licensee is excused from reporting to the Board at each of its quarterly meetings at the scheduled times for a probationer interview as long as Licensee does not engage in the practice of medicine in Oregon. Upon his return to Oregon, this requirement shall go back into effect.

4.2 Within 30 days from the approval of this Order, Licensee shall enroll in a structured physician's education program with ongoing monitoring of his practice to address the areas of need identified in the CPEP evaluation report. This program must be approved in advance by the Board's Medical Director. Licensee must successfully complete this program within 24 months from the approval of this Order. Licensee must also sign all necessary releases to ensure that quarterly progress reports and the final evaluation report from the education program are provided to the Board, and to allow for direct communication between the Board and program staff.

4.3 Licensee shall obey all federal, state and local laws, and all rules governing the practice of medicine in the state of Oregon.

4.4 Licensee stipulates and agrees that any deviation or violation from terms of this Order shall be grounds for discipline pursuant to ORS 677.190(18).

5.

This Order becomes effective the date it is signed by the Board Chair.

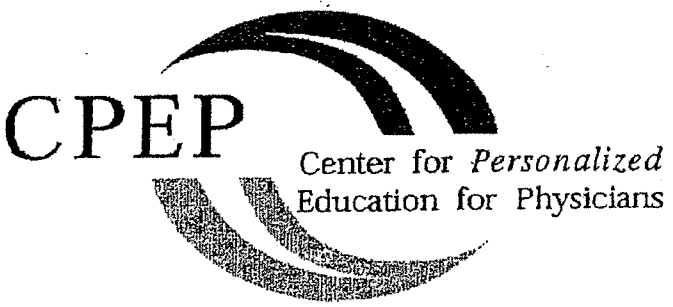
IT IS SO STIPULATED THIS 15th day of May, 2006.

VINCENT JOSEPH THOMPSON, MD

IT IS SO ORDERED THIS 13th day of July, 2006.

BOARD OF MEDICAL EXAMINERS
State of Oregon

DAVID R. GRUBE, MD
BOARD CHAIR



ASSESSMENT REPORT

For

Vincent Thompson, M.D.

August 4 – 5, 2005

A National Leader for Evaluating and Enhancing Physician Performance

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EXHIBIT B

I. The CPEP Assessment Process

CPEP, the Center for Personalized Education for Physicians, designed this Assessment for Vincent Thompson, M.D. The Assessment reflects Dr. Thompson's training and practice in family medicine. It included three clinical interviews based on patient charts that Dr. Thompson submitted from his former practice as well as hypothetical case discussions, and a written examination in electrocardiogram (ECG) interpretation. Simulated Patients represented clinical cases typically seen in a family medicine practice.

An administrator at Dr. Thompson's former practice in Newark randomly selected the charts that Dr. Thompson submitted for this Assessment. Charts were identified from Dr. Thompson's May 2005 office schedule.

The table below outlines the test modalities used in Dr. Thompson's Assessment and how each modality contributed to the Assessment.

	Areas Evaluated				
Test Modality	Medical Knowledge	Clinical Reasoning	Application of Knowledge to Practice	Documentation	Communication
Three Clinical Interviews – Family Medicine	♦	♦	♦	♦	♦
Review of Patient Charts	♦	♦	♦	♦	
Electrocardiogram Interpretation	♦				
Physician-Patient Communication Evaluation					♦
Simulated Patient Chart Note Analysis				♦	

Additional Assessment Components

- Review of:
  - Education, Training and Professional Activities
  - Practice Profile
  - Referral Source Information
- Health Information Review
- Cognitive Function Screen
- Observations of Participant Behavior

II. Participant Background

A. Review of Education, Training, and Professional Activities

CPEP obtained this information from conversations with and documents provided by Dr. Thompson.

Education

School	Degree	Years Attended
St. Joseph's University, Philadelphia, Pennsylvania	B.S.	1981 – 1985
Temple University, Philadelphia, PA	N/A	1985 – 1986
Ross University School of Medicine, Portsmouth, Dominica	M.D.	1986 – 1990

Post-Graduate / Residency Training

Specialty/Institution	Dates Attended
Obstetrics and gynecology internship, St. Luke's Hospital, Bethlehem, PA	July – December 1990
Family practice residency, Sacred Heart Hospital, Allentown, PA	1992 – 1995

Certifications

None

Licensure

Licensing State	Status
New Jersey	Active
Pennsylvania	Active
New York	Inactive
Oregon	Inactive

Practice History

Years/Description/Location

July 2005 – present: medical director and family practitioner in multi-specialty group practice, Family and Urgent Care Center, Toms River, NJ

July 2004 – June 2005: chief medical officer and adult medicine in multi-specialty group practice, Newark Community Health Centers, Inc., Newark, NJ

2002 – 2004: medical director and group family medicine practice, Coastal Family Health Center, Astoria, OR

1998 – 2002: chief executive officer, medical director, and family practitioner in multi-specialty group practice, Community Health Center of Buffalo, NY

1996 – 1998: medical director, associate residency director, and family practitioner, State University of New York at Buffalo Department of Family Medicine

Continuing Education

Continuing Medical Education Courses

Dr. Thompson reported a total of 252.25 hours of CME credit earned from 2002 to 2005:

- National Association of Community Health Centers (NACHC) Policy Forum, 2004 and 2005 (16 and 17.5 hours, respectively)
- HIV Regional Medical Update, University of Medicine and Dentistry New Jersey (UMDNJ), 2004; 2005 (1 hour each)
- Institute for Health Care Professionals Advanced Trauma Life Support Renewal, Portland Community College, 2004 (8 hours)
- International Bio-Terrorism, Thomas Jefferson University, 2004 (8.25 hours)
- NACHC Fall Primary Care Conference, NACHC, 2004 (26.25 hours)
- 15th Annual Regional HIV Medical Update, Center for Continuing Outreach and Education-AIDS Division, 2004 (8.25 hours)
- Academic Appointment: Physicians Assistant, Pacific University Portland, 2003 and 2004 (20 hours each)
- Phase II Diabetes Collaborative Training, Bureau of Primary Health Care California Primary Care, 2003 (11 hours)
- Medical Spanish Institute for Health Care Professionals, Clatsop County Community College, 2003 (16 hours)
- Spring Primary Care Conference, Community Health Centers and Primary Care Associations (CHAMPS)/Northwest Regional Primary Care Association (NWRPCA), 2003 (26.25 hours)
- Fall Primary Care Conference, CHAMPS/NWRPCA, 2002 and 2003 (26.25 and 26.5 hours, respectively)
- Academic Appointment: Department of Family Medicine, University at Buffalo, 2002 (20 hours)

Medical Literature Resources

Harrison's Principles of Internal Medicine, Kasper, D., et Al.

Harriet Lane Handbook: A Manual for Pediatric House Officers, Johns Hopkins Hospital

Current Medical Diagnosis and Treatment, Krupp, M., Chatton, M. (Eds.)

Griffith's Five Minute Clinical Consult, Dambro, M.

American Family Physician

Journal of the American Medical Association

Monthly Prescribing and Reference Guide

Family Practice Recertification Monthly

Family Practice Management

Dr. Thompson also refers to aafp.org, the official website of the American Academy of Family Physicians

Details of Malpractice Lawsuit History During Past Ten Years of Practice

None

B. Practice Profile

[CPEP obtained the following information from conversations with and documents provided by Dr. Thompson.]

Dr. Thompson completed medical school in 1990. He began his postgraduate training in obstetrics immediately following graduation, but left after failing to pass the medical licensing examination. After passing on a second attempt, Dr. Thompson entered and completed his family medicine residency. Dr. Thompson is not board certified; he took the family practice certification exam once, but was not successful.

Dr. Thompson joined his current practice in July 2005. He does outpatient adult medicine in a group multi-specialty practice in Toms River, NJ. He works five days per week and sees 20 patients per day. His practice is currently all adults. Dr. Thompson hopes that he will see pediatric patients in the future, but it is not part of his current responsibilities. He does not do obstetrics. Dr. Thompson listed the procedures he performs in the outpatient setting as: laceration repair, minor skin procedures, punch biopsy, and colposcopy.

C. Reasons for Assessment

[The Oregon Board of Medical Examiners and Dr. Thompson provided CPEP with the following information.]

The Oregon Board of Medical Examiners (Board) notified Dr. Thompson in August 2004 that complaints had been received regarding his care and treatment of several patients. The concerns involved: lack of history and physical examination and prescribing medications without justification; failure to provide adequate supervision of physician assistants; and delegation of medical decisions to nursing staff beyond their scope of practice; and falsification of medical records to reflect that he was seeing patients seen by a nurse. At the request of the Board, Dr. Thompson referred himself to CPEP for an evaluation of his clinical skills in family practice.

Through this Assessment, Dr. Thompson seeks to satisfy any concerns the Board may raise, and gain insight into any areas for educational improvement.

III. Evaluation Components

A. *Clinical Interviews*

Clinical Interview #1

The consultant is a board-certified family physician, currently practicing in the Denver metropolitan area. The consultant first commented on the records he reviewed. Dr. Thompson utilized a template form for his encounters. The consultant commented that the documentation was brief and, at times, reflected inadequate evaluation. For example, a 29 year-old female was seen for a physical exam and complained of headaches and rib pain. She reported a depressed mood and had been on Zoloft in the past. There was no additional information in the encounter about the rib pain, depression, or headache. His exam consisted of vital signs, check marks in locations designated by the template form, and a hand written note stating the heart had a regular rate and rhythm and lungs were clear. He planned for the patient to resume the Zoloft for depression. He listed costocondriasis (sic) as a diagnosis, but did not have a treatment plan for this diagnosis. He ordered blood work and referred her to gynecology, and referred her to optometry for her head aches. The consultant found that this was an inadequate evaluation for the patient's three complaints, that the record did not substantiate his decisions regarding the treatment of the depression, and that there was no treatment plan for the patient's costochondritis.

The consultant presented hypothetical cases and scenarios for review. He first asked Dr. Thompson to describe a routine physical examination for a 58 year-old male. The patient was 5' 9", weighed 210 pounds and had a blood pressure reading of 166/88. The patient smoked and complained of occasional erectile dysfunction. Dr. Thompson adequately covered the patient's medical history and a basic physical examination. He would offer cancer-screening education and counsel the patient about smoking cessation and weight loss. Dr. Thompson would not perform a prostate specific antigen (PSA) unless the prostate felt abnormal upon examination. The consultant noted, however, that Dr. Thompson was unfamiliar with the criteria for PSA testing. Dr. Thompson would recommend a colonoscopy and order laboratory tests that included lipids, a treadmill test, a urine analysis (UA), chemistry, liver function tests (LFTs) and a chest x-ray (CXR). The consultant provided specific hyperlipidemia values, which Dr. Thompson recognized were elevated. Dr. Thompson offered treatment goals, however, the consultant noted that Dr. Thompson's goals differed from the National Cholesterol Education Program (NCEP) guidelines. When asked about lipid management, Dr. Thompson advised that he would prescribe Lipitor and was familiar with the side effects and precautions for this medication. He knew that he would need to titrate Lipitor but gave an incorrect maximum dose for this medication. He noted that he would want to confirm the dosage for this drug. Dr. Thompson advised the consultant that he was unfamiliar with the medications used to lower triglycerides, or specific methods to increase high-density lipids (HDLs).

The consultant next asked about the patient's hypertension. Dr. Thompson was aware that Accupril was an angiotensin converting enzyme (ACE) inhibitor. Although he was familiar with the known side effects of dizziness and lightheadedness, Dr. Thompson failed to mention the possibility of a cough. He further advised that he would add combinations such as

hydrochlorothiazide, but stated he would use an "ARC." The consultant thought Dr. Thompson meant to say ARB (angiotensin receptor blocker), as he referred to Avapro.

When the consultant asked about the patient's elevated blood sugar of 180, Dr. Thompson stated he would not have treated this. The consultant expressed concern that Dr. Thompson did not demonstrate knowledge of the criteria for diagnosing diabetes, although he mentioned metformin and was aware of the foremost side effects associated with this drug: gastrointestinal (GI) and muscle problems associated. The consultant noted that Dr. Thompson was not familiar with any contraindications for metformin, and had limited knowledge of other drugs available to treat diabetes, other than sulfonylureas. The consultant found that Dr. Thompson had limited information about thiazolidinediones (TZDs). When the consultant described the patient's treadmill test results, Dr. Thompson interpreted these results as borderline, whereas the consultant had provided positive test results. However, Dr. Thompson would refer the patient to a cardiologist. Dr. Thompson stated that he typically prescribed beta-blockers, aspirin, nitrates, and ACE inhibitors for patients with a history of myocardial infarction (MI), and the consultant agreed.

The consultant described a young female complaining of acute back pain after moving a jet ski. Dr. Thompson outlined an exam that would appropriately focus on the musculoskeletal and neurologic systems. He described range of motion, sensory exam, and Babinski reflex. Dr. Thompson would use a text of physical examination to determine a corresponding dermatome, if sensory loss were present. He required prompting to consider strength, deep tendon reflexes, and straight leg raise. If the examination were unrevealing, Dr. Thompson would order an MRI. When the patient requested pain medication, Dr. Thompson said he would prescribe Toradol. The patient stated she was allergic to this drug, and Dr. Thompson said he would become suspicious at this point that that the patient was drug seeking. Dr. Thompson would inform the patient that he would not prescribe any narcotics unless she was prepared to undergo a computed tomography (CT) scan or magnetic resonance imaging (MRI). The consultant inquired about the possible role of Ultram for such a patient, but Dr. Thompson's knowledgeable about this drug was superficial. The consultant concluded that Dr. Thompson understanding of low back pain and pain management in this circumstance was incomplete.

The consultant asked Dr. Thompson to discuss a 50 year-old well-woman examination. Dr. Thompson advised that mammograms should begin at age 40 and continue every two years for life; the consultant commented that this is within the spectrum of recommendations of the U.S. Preventive Services Task Force. He indicated several risk factors for breast cancer, but did not mention heritage or BrCa-positive status. He would recommend a colonoscopy for colon cancer screening every five years; the consultant thought that most physicians would recommend this mode of screening once every ten years in the average or low risk individuals. Dr. Thompson incorrectly indicated the age at which routine pneumonia vaccination should be offered; he was correct in that high-risk populations should be immunized earlier. He would offer tetanus immunization for those at risk. When the consultant asked about abnormal Papanicolaou (Pap) smear results, specifically atypical squamous cells of undetermined significance (ASCUS), Dr. Thompson stated he would either repeat the Pap smear in three months time or order a

colposcopy. Although these are reasonable options, the consultant commented that Dr. Thompson did not demonstrate awareness of human papilloma typing in the triage of minor Pap smear abnormalities.

A hypothetical 12 month-old with a fever, vomiting and crying was discussed next. Dr. Thompson noted that he did not have recent experience treating pediatric patients. He provided a reasonable list of infective processes that he would consider. Dr. Thompson mentioned that if he found otitis media, he would prescribe amoxicillin; he cited an outdated dose. If the patient were allergic to penicillin, Dr. Thompson would suggest reasonable alternatives, noting that he would need to look up the dosages. If a source of infection were not obvious, Dr. Thompson would order a chest x-ray (CXR), complete blood count (CBC), seven-item chemistry panel and a urinalysis (UA), which would be reasonable, according to the consultant.

Clinical Interview #2

The consultant is a board-certified family physician, currently practicing in a metropolitan area. The consultant discussed two of the charts submitted by Dr. Thompson, as well as hypothetical cases.

The consultant first asked Dr. Thompson to discuss some indications for routine physicals for young adults, prompted by her review of chart of a 34 year-old male. Dr. Thompson proceeded to discuss the components of his typical history and physicals. He advised he generally obtained a full family and social history, substance abuse and sexual history, focusing on the latter because of the high-risk nature of this population group. The consultant commented that the chart she reviewed included a brief history and was not consistent with the thorough history Dr. Thompson described during the interview. Dr. Thompson state he would order routine laboratory tests, including a CBC, due to the high prevalence of anemia in this demographic because of poor diet, update immunizations as needed, and review cardiac risk factors. The consultant commented that, despite some probing, Dr. Thompson was unable to differentiate between the indications for a routine physical examination versus routine screening tests.

The consultant inquired about Pap smears. Dr. Thompson indicated that these were performed on an annual basis for this age group, as well as Chlamydia testing for women 25 and under, which the consultant thought was appropriate. Dr. Thompson said that he did not order Thin Prep testing, although he thought that the organization he worked for was planning to change to Thin Prep testing together with human papillomavirus (HPV) testing. The consultant questioned Dr. Thompson about the relationship between HPV testing and cervical cancer. Although Dr. Thompson was aware of the association, he did not know how HPV testing along with Pap screening was used in the management of Pap smears, and how this might improve management and reduce referral for colposcopy. Dr. Thompson stated that patients with ASCUS or low-grade squamous intraepithelial lesions (LSIL) were referred for a follow-up colposcopy. The consultant found Dr. Thompson uninformed about the risk of progression to cervical cancer depending on Pap test results and HPV status.

Next the consultant talked about contraception. Dr. Thompson stated that Depo-Provera was popular in his practice. He was aware of the usual side effects, and appeared familiar with the recent black box warning about the risk of osteoporosis.

Returning to Dr. Thompson's 34 year-old patient's record, the consultant asked about a visit that occurred after the physical that indicated elevated triglycerides and was signed by Dr. Thompson. According to Dr. Thompson, this was a nurse visit to discuss lab results and to receive diet education. The consultant was unable to discern the nature of this visit, such as what took place during the visit, that the nurse, rather than Dr. Thompson, had seen the patient, or the patient disposition. Dr. Thompson told the consultant that this information would be documented on the lab result sheet, which he stated was not included in the copied records sent. The consultant opined that the documentation was both uninformative and confusing.

The consultant then discussed Dr. Thompson's 70 year-old female patient who was seen for a blood pressure check. She complained about difficulty with her vision. Her blood pressure at the time of the visit was 210/120, and her blood sugar was 202. A complete physical examination was undertaken. An ECG indicated that the patient had atrial fibrillation and left ventricular hypertrophy. The chart note stated that the patient had been referred to a cardiologist. The consultant questioned Dr. Thompson about the management of this patient, and he advised that the patient was prescribed clonidine. The consultant agreed that administration of clonidine would be appropriate, but commented that there was no documentation in the record to support that this had occurred. In addition, there were no subsequent blood pressures documented during that visit.

Dr. Thompson appropriately described how to evaluate and manage new-onset atrial fibrillation, and provided differential diagnoses for precipitating etiologies. Dr. Thompson stated he did not prescribe digoxin due to its waning popularity, but when the consultant questioned him more closely, he was unable to quote literature to provide reasoning behind this assertion. Dr. Thompson appeared familiar with the long-term management of atrial fibrillation—the major goals being control of the heart rate and the prevention of thrombosis and clots. He advised that he usually consulted with a cardiologist about the appropriateness of Coumadin therapy. If prescribed, Dr. Thompson would follow the patient with international normalized ratio (INR) at a reasonable interval of every two to four weeks, and was aware that the INR should be between two and three.

The consultant inquired about the management of acute hypertension. Dr. Thompson advised that he would prescribe an oral dose of 0.1 mg of clonidine and titrate upward. However, if the patient did not respond to the medication and there were indications of acute ECG changes, Dr. Thompson would appropriately send the patient to the emergency room (ER). The consultant questioned Dr. Thompson about symptoms of emergent hypertension, and he correctly identified headaches, palpitations, and chest pain. The consultant then asked Dr. Thompson how he diagnosed hypertension, the treatment goals and some of the categories. Dr. Thompson was not familiar with the new category of pre-hypertension, or the different levels of hypertension as described in the most recent report of the Joint National Committee on the Prevention, Detection,

Evaluation, and Treatment of High Blood Pressure (JNC-7). Dr. Thompson had heard of the JNC-7 Report, but was not familiar with its content. He stated he would prescribe medications according to the ethnicity of the patient and take into consideration co-morbidities, such as using an ACE or ARB for a diabetic patient. He would arrange for the patient to return in five to seven days for further assessment. Dr. Thompson indicated that he generally increased the dose before adding a second medication in order to keep the regimen simple. When the consultant queried Dr. Thompson about different blood pressure targets for diabetics, Dr. Thompson indicated that they should be lower than for non-diabetic hypertensive patients, but he was unable to state the specific level.

Management of chronic pain patients was discussed next. Dr. Thompson stated that prior to prescribing medications for a patient with chronic pain, the patient was required to enter into a pain contract. Per Dr. Thompson, the contract specified the patient's pharmacy; that the prescription would not be refilled without a physician's order; that the patient use a single prescriber, and that care would be terminated for any violation of the contract. Dr. Thompson commented that he avoided accepting care of new chronic pain patients and that a pain management specialist was available in his community.

The consultant asked Dr. Thompson about nonsteroidal anti-inflammatory drugs (NSAIDs) and their side effects. Dr. Thompson was aware of the gastrointestinal side effects; he would add an H2 blocker for patients who used the drugs long term to avoid some of the adverse effects of the drugs. The consultant commented that H2 blockers were not effective in preventing GI bleeding complications, and that a better choice would be a proton pump inhibitor (PPI). The consultant added that, despite prompting, Dr. Thompson did not mention the potential for renal side effects of chronic NSAIDs. When asked about Tylenol toxicity, Dr. Thompson responded that he limited this drug to less than 1200 mg a day in combination with other medications, and correctly stated that the upper limit for Tylenol was approximately 3600 mg.

Clinical Interview #3

The consultant is a board-certified family physician, currently practicing in a metropolitan area with prior experience in a smaller community.

The consultant reviewed five charts from Dr. Thompson's prior practice. Notes were brief and in some instances the information was inadequate to understand the patients' presentations or whether Dr. Thompson's management was appropriate. For example, Dr. Thompson saw a patient for whom the history of the present illness was "Pt. states 'I want to be checked for STD'" with no additional information documented. The consultant was not able to determine the patient's age, relevant exposures, or any other information.

The consultant discussed hypothetical cases during the interview, the first of which was a 60 year-old male with redness and swelling of the left ankle and calf. The swelling had been present for three days prior to the appointment. According to the consultant, Dr. Thompson would ask appropriate questions about the patient's history and then considered the diagnoses of cellulitis and deep vein thrombosis (DVT). He described a complete physical examination, and would

obtain an ultrasound to confirm the DVT diagnosis. If the ultrasound indicated that the patient had a DVT above the knee, Dr. Thompson would admit the patient to the hospital to initiate intravenous heparin management. If the DVT were located below the knee, Dr. Thompson would prescribe warfarin and treat the patient on an outpatient basis. When the consultant advised that the ultrasound was negative, Dr. Thompson proposed prescribing Keflex. The consultant thought this was an acceptable choice, but noted Dr. Thompson should have taken into consideration the patient's allergy to penicillin. The consultant advised Dr. Thompson that the following day, the patient complained of worsening swelling and erythema. Dr. Thompson would continue with the same treatment plan. However, the consultant commented that, at this point, Dr. Thompson should have considered methicillin resistant staphylococcus aureus (MRSA).

The consultant next discussed a 35 year-old female patient with asthma. Dr. Thompson would inquire about whether the patient smoked and how frequently she used her inhaler. The consultant noted that Dr. Thompson asked only a few questions about asthmatic triggers. Dr. Thompson said that he would obtain a peak flow, pulse oximetry, and spirometry, if available, and would treat the patient with nebulized Proventil. He inquired about symptoms at rest, and for moderate to severe asthma would have started the patient on either Flovent or Advair. He would also prescribe Singulair but, according to the consultant, Dr. Thompson did not know the drug category or mechanism of action. Dr. Thompson suggested a CXR and asked the patient to return for a follow-up re-evaluation in one to two days. If the patient did not show improvement, Dr. Thompson would refer her to a pulmonologist, if she appeared distressed, he would admit her to the hospital and arrange for a nebulizer treatment. The consultant found this discussion largely appropriate.

A 55 year-old female who had returned to Colorado following a long plane ride from Alaska the day prior to the consultation was described next. The patient complained of feeling exhausted and although she appeared ill, her vital signs were normal. Following a physical examination, Dr. Thompson would order a CBC to check for anemia, obtain blood chemistries including electrolytes, creatinine, glucose, and liver function tests, a UA and an ECG. Dr. Thompson stated that if these tests proved negative, he would send the patient home and encourage her to seek medical attention in an ER if her symptoms worsened. According to the consultant, the long plane ride was a significant risk factor for a diagnosis of large bilateral pulmonary emboli, which Dr. Thompson did not appreciate.

The next patient discussed was a 67 year-old female with fatigue, cough, and symptoms of an upper respiratory infection that had lasted for two days. The patient complained of pain in her right lower chest with deep breathing. The consultant advised that her vital signs were: temperature 101.5°, heart rate 76, respiration 32, and blood pressure 128/84. The patient had a past medical history of hypertension, controlled with hydrochlorothiazide and Lisinopril. Dr. Thompson said he would want a CBC, chemistry profile, and a CXR. When informed that the CXR was negative, Dr. Thompson stated he would want to obtain a ventilation-perfusion scan. Dr. Thompson learned that this scan was positive for a pulmonary embolus and he suggested admission to the hospital. Dr. Thompson would begin treatment with heparin or low molecular

weight heparin, followed by Coumadin. He would monitor her prothrombin time, and keep the INR level between two and three. He further noted the need to taper the Coumadin after three weeks. The consultant expressed concern that while there is no absolute standard for Coumadin therapy, most clinicians would continue Coumadin therapy for at least six months. The remainder of Dr. Thompson's discussion was appropriate.

The consultant presented a 39 year-old woman with fatigue, blurry vision, and nausea. She had experienced Candida vaginitis three times in the previous six months, as well as three documented episodes of a urinary tract infection in the past year. She complained of frequency, urgency, and burning with urination. The patient's vital signs were normal, and she weighted 235 pounds. Dr. Thompson inquired about her social history, sexual contacts, and whether she practiced safe sex. He asked about any history of hepatitis or human immunodeficiency virus (HIV), and requested an HIV test, CBC, electrolytes, UA, and CXR. The consultant advised Dr. Thompson that the UA indicated numerous white blood cells and was positive for nitrite. Dr. Thompson proposed treating the patient with Bactrim for seven days. The consultant expressed concern that this patient was a classic presentation of new onset Type 2 diabetes mellitus (DM), which Dr. Thompson failed to diagnose.

The consultant then discussed a 58 year-old male complaining of extreme thirst. Dr. Thompson requested a complete history and would order a glucose test and a UA. The consultant advised him that the UA was positive for glucose and ketones and that the glucose was 490. Based upon this information, Dr. Thompson would obtain arterial blood gases to determine if acidosis were present. He would admit the patient to the hospital for intravenous insulin, and consider diabetic coma and shock. The consultant noted that Dr. Thompson mentioned long-term risks such as arterial disease, cardiac disease, renal disease, stroke, and retinal damage. When the consultant asked Dr. Thompson if diabetic ketoacidosis (DKA) were likely in a patient of this age, Dr. Thompson was not certain. He was unaware of what type of diabetes was more likely to result in DKA. Dr. Thompson failed to mention hyperosmolar coma. Dr. Thompson's management following discharge from the hospital would include metformin, a sulfonylurea, or Actos or Avandia. He would also monitor the patient's renal function.

When the consultant questioned Dr. Thompson about the etiology of Type 2 DM, he stated that it resulted from a decreased number of insulin receptors, which left glucose unabsorbed. He described Type 1 DM as being a hereditary disease and a deficit of islet cells in the pancreas. The consultant agreed that Type 1 DM involves a deficit of islet cells in the pancreas, but frequently results from a viral infection that destroyed the islet cells in a susceptible individual. However, hereditary factors play a much stronger role in type 2 diabetes. Dr. Thompson incorrectly described the mechanism of action of metformin, but correctly depicted the mechanism of action for Actos and Avandia.

The final patient described was a 38 year-old male with severe abdominal pain. Dr. Thompson pursued an appropriate history and described an adequate abdominal examination. When the consultant told Dr. Thompson that the patient was most tender in the left lower quadrant, Dr. Thompson considered gall bladder disease and appendicitis. He would order an ultrasound,

CBC, and chemistry panel and would propose calling a surgeon to evaluate the patient. When the consultant asked Dr. Thompson about other possible diagnoses, Dr. Thompson mentioned diverticulitis, impaction, torsion, and colitis. The consultant commented that the patient actually had diverticulitis, and that pain in the left lower quadrant would be unlikely to indicate either gall bladder disease or appendicitis.

B. Written Examinations

Electrocardiogram Interpretation

Dr. Thompson orders and reads ECGs in his practice with routine over reading. Dr. Thompson's responses to the ECG examination were considered within the context of his family practice.

In this exercise, CPEP asked Dr. Thompson to note the rate, intervals, and axis on one ECG. He was correct for rate and QRS duration, but incorrect for PR duration, QT interval; his QRS axis was correct in degrees, but reversed in polarity (negative instead of positive).

Dr. Thompson then analyzed ten ECG tracings and provided a description, interpretation and course of action for each. His notes showed that he had an organized approach to reading ECGs, but it appeared he was inconsistent in his ability to detect abnormalities. He described all-important features of one ECG, and was partially correct for the remaining nine. He made a variety of errors and omissions, including failing to note Q waves, ST and T wave changes, and over reading changes that were not present or insignificant.

Dr. Thompson's interpretations were correct in one, and partially correct in nine tracings. Many errors were corresponded to errors in his descriptions. Of the six tracings for which Dr. Thompson needed to consider infarct or ischemia as the cause of the pattern, he identified three, and in two cases, read ischemic changes when absent.

Plans were correct and thorough in response to one tracings, and correct, but without detail, in an additional tracing. His plans were partially correct in six cases, and wrong in two instances. The majority of his plans were safe, and many included cardiology referral. However, three patients might have been put at risk by Dr. Thompson's plans, largely because of failure to address the possibility of acute ischemia and to respond accordingly.

Thus Dr. Thompson did not the show adequate ability to analyze ECGs. The consultant reviewer recommended additional learning in ECG interpretation and creation of plans in response to abnormal ECGs.

C. Physician-Patient Communication Evaluation

The communication consultant assessed Dr. Thompson's communication skills by observing his interactions with three Simulated Patients (SPs). The patient cases presented with the following complaints: stomach pain following recent gall bladder surgery; psoriasis, and numbness on the right side.

During the SP interviews, Dr. Thompson utilized a pre-printed form, which he stated kept him on track and gave him confidence that he would not overlook anything. Dr. Thompson appeared professional and used open body language. One SP remarked that Dr. Thompson had a calming, gentle demeanor and focused on the positive. Another commented that Dr. Thompson demonstrated a non-judgmental attitude about the fact that the SP smoked. Dr. Thompson explained most of what he was doing during the physical examinations and throughout the interviews. However, although Dr. Thompson established a comfortable pace at the beginning of the interview, two SPs commented that he interrupted them and did not allow them to finish what they were saying.

The consultant concluded that Dr. Thompson had the skills necessary to be an effective communicator.

D. Patient Care Documentation

Review of Documentation – Patient Charts

The consultants reviewed several outpatient charts from Dr. Thompson's practice. The charts included a template checklist for physical examinations, which did not provide adequate information about the patient's condition. There was insufficient space to include a detailed assessment, differential diagnosis, or treatment plan, and the flow appeared illogical. Medication lists and problems lists both past and current were not present in the records. Notes written by Dr. Thompson, although legible, were brief, and it was difficult for the consultants to gain an overall picture of the patient. There was however, evidence that Dr. Thompson followed up on abnormal laboratory results and notified the patient. The consultants opined that, overall, the documentation was unacceptable, and it would be difficult to assume care of Dr. Thompson's patients based on the minimal information provided.

Review of Documentation – Simulated Patient Encounter Progress Notes

Dr. Thompson was asked to document a progress note for each Simulated Patient encounter (See Section III. C. above).

Dr. Thompson's SP notes were lengthy and dictated in a SOAP format. Dr. Thompson included past medical, family and social histories; inquired about the present illness; noted current medications, allergies and whether the patient used tobacco, drugs and alcohol. The physical examinations were focused appropriately. Treatment plans were outlined, and patient education was documented.

Dr. Thompson sometimes dictated information out of order. For example, in one note he dictated historical information in the objective (physical exam) section, and in another, he placed historical information in his plan. In one instance he began dictating the history of present illness, moved to allergies and obstetric and gynecologic history, then returned to the history of present illness. In one case, Dr. Thompson appropriately documented secondary diagnoses identified, and narrated a plan to address these problems. However, it would have been easier to review this data if he had documented a separated, and enumerated, plan for each problem.

Overall, the notes were acceptable. Dr. Thompson should improve the organization of his notes, however.

E. Cognitive Function Screen

Dr. Thompson's test results on the cognitive function screen were within normal limits and did not indicate the need for further evaluation.

F. Review of Health Function

Dr. Thompson submitted a letter from his physician dated July 21, 2005. Review of this letter revealed no conditions that should impact Dr. Thompson's ability to practice medicine.

G. Observations of Participant Behavior

Dr. Thompson was pleasant throughout the Assessment process. He was respectful to CPEP staff and clinical consultants. He conducted himself in a professional manner during the Assessment. He submitted all the required documentation in a timely manner.

IV. Assessment Summary

CPEP's Assessment conclusions about the participant-physicians are based solely upon our review of initial documents provided by the participant, the referring agency or institution, assessment findings, reports, interviews and meetings with the physicians in question. Our findings are not based upon the determinations or conclusions of peer review, judicial or state licensing bodies.

This Assessment is intended to provide an evaluation of Dr. Thompson's clinical abilities in family medicine. An Assessment such as that done by CPEP does not involve direct observation of the participant-physician at work. Our conclusions, therefore, can address only whether the physician possesses the knowledge and judgment necessary to perform. We cannot predict actual behavior.

A. Medical Knowledge

During this Assessment, Dr. Thompson demonstrated broad knowledge that was superficial in several areas important to family practice.

Dr. Thompson did well in discussions concerning contraception and medical treatment of chronic coronary artery disease. However, he showed the need to improve his abilities in ECG interpretation, and showed that he was not familiar with the criteria for a positive stress test. His knowledge of deep venous thrombosis and most aspects of pulmonary embolism and asthma were adequate.

Dr. Thompson was aware of most issues to consider in the area of routine health maintenance, but lacked depth and detail in a variety of specific issues. He had a general understanding of the treatment of hyperlipidemia, but used goals that differed from respected guidelines. Likewise, he was not familiar with JNC-7 guidelines for hypertension. Dr. Thompson knew of the association of HPV with cervical cancer, but could not estimate the rate of progression for dysplasia or current management decisions using HPV testing. Dr. Thompson was familiar with tools to manage chronic pain patients, yet he lacked knowledge of certain drug treatments and alternative treatments; he was not facile with important routine components of evaluation for a patient with low back pain. He did understand the signs of drug seeking behavior.

Dr. Thompson's demonstrated knowledge in both diabetes and atrial fibrillation was variable. He showed several gaps in his knowledge of pharmacology. He had limited knowledge concerning dosages of a variety of drugs, and the mechanism action of Singulair. Dr. Thompson did not appear to have current understanding of management of otitis media in children.

B. Clinical Reasoning

Dr. Thompson demonstrated clinical judgment and reasoning that was generally sound, though inconsistently applied. Although in hypothetical discussions he was able in most cases to gather adequate information to proceed with a diagnostic or treatment plan, his actual records did not show that he consistently did so in practice. In one discussion, Dr. Thompson showed that he knew how to address a patient with an acutely elevated blood pressure in the office. However, his patient records did not support that he had managed the patient this way; Dr. Thompson stated that this was a documentation issue, but the consultant was not able to discern this from the data she reviewed. In a few hypothetical scenarios, Dr. Thompson showed that he was knowledgeable about certain conditions, but he did not recognize more subtle or disguised presentations. In as much, he did not appear to have adequate suspicion for serious conditions when formulating his differential diagnoses. When clearer cases were presented, Dr. Thompson responded appropriately to acuity of illness. He appeared alert to a pattern indicative of drug seeking behavior. In one case, Dr. Thompson did not show flexibility of thinking in a setting of a patient failing to improve.

C. Communication

Dr. Thompson showed adequate physician-patient communication skills and demonstrated the ability to put the SPs at ease with his calm and gentle demeanor. He did not always allow the Simulated Patients to complete their thoughts.

Dr. Thompson's interactions with CPEP staff and consultants were appropriate.

D. Documentation

The notes generated during the Assessment provided detailed information and demonstrated that Dr. Thompson had the ability to provide adequate documentation. His organization could be improved.

In contrast, the notations in Dr. Thompson's practice charts were considered scanty at best, and the documentation was incomplete. The consultants opined that they were unable to gain a clear picture of the patient, and would not be able to assume care based on the information provided.

E. Review of Health Information and Observations of Behavior

The results of a physical examination Dr. Thompson underwent in July 2005 did not identify any conditions that should interfere with the practice of medicine. Dr. Thompson's cognitive function screen results were within normal limits.

Dr. Thompson was pleasant and cooperative during the Assessment.

F. Summary

Overall, Dr. Thompson demonstrated broad but superficial knowledge of outpatient family medicine. His judgment and clinical reasoning skills were variable, and his application of knowledge was, at times, poor. Dr. Thompson demonstrated the ability to provide adequate charting, as indicated in the notes for the SPs, although his practice charts were poorly documented. His communication skills with peers and simulated patients were adequate. There were no health concerns identified that would impact his ability to practice and his cognitive function screen did not suggest the need for neuropsychological evaluation. Some of the educational needs identified could correlate with the reasons Dr. Thompson was referred for an Assessment.

V. Implications and Recommendations

Dr. Thompson appeared open to feedback and to addressing any identified areas of need during the Assessment. It was unclear if he had insight into the issues that prompted his referral or his educational needs.

Areas of Demonstrated Need (including, but not limited to):

Knowledge:
A general review of family medicine, including;

- Diabetes, including:
  - Pathophysiology;
  - Acute complications;

  - Pathophysiology and risk factors;
  - Oral glucose lowering medications.
- JNC-7 guidelines for hypertension;
- Pap smear management, specifically the role of HPV testing in the triage of minor Pap smear abnormalities, and the risk of progression from various degrees of dysplasia to cancer;
- Musculoskeletal pain and treatment alternatives;
- Awareness of identified genetic risks for certain cancers, such as breast cancer;
- Current treatment recommendations for otitis media in pediatric patients;
- Current management of atrial fibrillation and the evidence supporting contemporary treatment regimens;
- Understanding of ETT results;
- Duration of anticoagulation after pulmonary embolism;
- Various aspects of pharmacology, including side effects of ACE inhibitors; maximal doses of common medications, familiarity with a broad spectrum of glucose lowering agents; Ultram; Singulair; side effects and management of side effects of NSAIDs;
- Hyperlipidemia, including NCEP ATP III guidelines and treatment goals, and medication options;
- Indication for comprehensive health evaluations;
- Routine Health screening, including:
  - Indications for PSA testing;
  - Age at which universal pneumococcal immunization should be offered to adults;
  - Recommended frequencies for screening colonoscopy;
- Electrocardiogram interpretation and formulation of plans in response to abnormal ECGs.

Judgment:
- Consistently thorough patient evaluation;
- Application of knowledge in practice;
- Index of suspicion for serious conditions.

Documentation:
- Inclusion of problem and medication lists;
- Consistent documentation of assessments, differential diagnoses, and plans;
- Sufficiently detailed notes to allow another member of the healthcare team to assume or continue care.

Educational Recommendations (including, but not limited to):
The following educational recommendations provide the foundation for the Educational Intervention. Further detailed educational planning may include additional activities.

- Educational Preceptor: Dr. Thompson should establish a relationship with an experienced educational preceptor in family medicine. This involves regularly scheduled meetings to review cases and documentation, discuss decisions related to those cases,

review specific topics, and make plans for future learning. Continuing Medical Education and Self-Study: Dr. Thompson should engage in continuing medical education courses and self-study which include, but are not limited to, the topics indicated in areas of demonstrated need.

- Continuing Medical Education and Self-Study: Dr. Thompson should engage in continuing medical education courses and self-study which include, but are not limited to, the topics indicated in areas of demonstrated need.
- Adoption of charting system that includes problem and medication lists.
- Documentation course or coaching, with follow-up.

Based on the findings of this report, Dr. Thompson needs to participate in structured, individualized education to address the identified areas of need. Some of these areas will require moderate time and commitment. Others, such as Dr. Thompson's application of knowledge to patient care, can be challenging to remediate and may require ongoing monitoring over an extended period of time to ensure success. Dr. Thompson will need to commit himself fully to modify his approach in practice.

CPEP can provide information about the development of an Educational Intervention including educational objectives reflective of Dr. Thompson's areas of need, specific educational activities, timeframes, and evaluation processes. A CPEP Associate Medical Director for Educational Intervention would actively monitor progress and compliance with the plan, notifying both Dr. Thompson and the Board on an ongoing basis. Such an Intervention would likely require moderate to significant time and effort on the part of Dr. Thompson.

VI. Signatures

The Assessment Report reflects the effort and analysis of CPEP's Medical Director, Associate Medical Directors, and administrative staff.

CPEP Representatives

Elizabeth Grace, M.D.
Medical Director, Assessment Services

9-27-05
Date

Debbie Waugh, L.C.S.W.
Director, Program Services

9/27/05
Date

Participant

My signature below indicates that I have had the opportunity to review the Assessment report. It does not necessarily mean agreement with or approval of the report.

Vincent Thompson, M.D.

9.22.05
Date

PARTICIPANT RESPONSE TO CPEP ASSESSMENT REPORT

(Optional)

Please type or write your response. You may attach additional pages. Only comments received by the identified due date will be attached. Articles, charts, research papers and expert opinions will not be accepted.

Vincent Thompson, M.D.

9.22.05

Date

ASSESSMENT FOCUS AREAS AND PROGRAM DESIGN

The Assessment is designed to evaluate the physician-participant through use of specialty-specific, individualized testing tools. An Associate Medical Director for Assessment Services oversees the Assessment and attends clinical interviews to ensure that the process is reflective of the physician-participant's practice specialty and also takes into account any noted reason for referral. Results from the physician-participant's performance in each assessment modality are incorporated into an Assessment Report. The Assessment Report reflects the effort and analysis of CPEP's Medical Director, Associate Medical Director and administrative staff.

DESCRIPTION OF FOCUS AREAS

Clinical Judgment and Reasoning reflect the physician's thought processes and integration of clinical knowledge with the patient's presentation, history, and other health information to determine acuity and urgency and then to identify a treatment plan or approach, while considering risks or benefits of proposed plan(s). Application of Knowledge is an important component of clinical judgment and reasoning that shows how the physician uses his/her knowledge and clinical reasoning in actual patient care. CPEP's evaluation of the physician's application of knowledge is based on review of actual patient charts and answers an important question: does the physician use his knowledge appropriately in the treatment of patients in the office and/or hospital settings?

Medical Knowledge describes the physician-participant's understanding of the specialty-specific components of medicine necessary for clinical evaluation and problem solving in practice. Three key elements of knowledge in topics relevant to practice are evaluated: the physician's foundation of knowledge, depth and breadth of understanding, and current awareness of available options and medical approaches.

Patient Care Documentation indicates the physician's understanding and ability to create effective written notes that explain diagnostic considerations, supporting data, risks or other considerations, and treatment approach, both in the context of one encounter as well as multiple interactions over time.

The physician's Communication Skills reflect the ability to verbally express and receive information, as well as integrate verbal and non-verbal observations in interactions with peer professionals and patients.

DESCRIPTION OF EVALUATION TOOLS

Selection of the testing modalities varies with each Assessment. Please refer to the Assessment Report, *Section I, CPEP Assessment Process*, for further information.

Structured Clinical Interviews

Clinical Interviews are oral evaluations of the physician-participant conducted by physician-consultants in the same specialty area. Each consultant is certified through a Board recognized by the American Board of Medical Specialties. The interview is conducted in the presence of the Associate Medical Director. The consultant asks about patient care management based on charts submitted by the participant and hypothetical case scenarios. Radiologic studies or videotapes of surgical procedures may also be used in the interview process. These ninety-minute oral interviews are used to evaluate the physician-participant's medical knowledge, clinical judgment, and peer communication skills.

Note: On occasion, physician-participants are unable to provide charts from their practice, either because they have not been in practice for a number of years or because the facility at which they work is unable or unwilling to release them. In these situations, hypothetical case scenarios are used as the basis for the interviews.

Multiple-Choice Question (MCQ) Knowledge Test

Multiple-choice question examinations are targeted to the physician-participant's specialty and practice. Tests in certain specialties are selected from a national clinical content library. Analysis of the physician-participant's performance identifies areas of strength as well as areas where further learning is needed. These specialty specific multiple-choice questions are not standardized and do not provide normative data.

Electrocardiogram (ECG) Interpretation

Physician-participants whose practice includes reading ECG tracings are presented with eleven ECG tracings and asked to provide an interpretation and course of action for each.

Fetal Monitor Strips

Physician-participants providing obstetric care in their practice are asked to read twelve fetal monitor strips and provide an interpretation and course of action for each strip.

Physician-Patient Communication Evaluation

Effective communication and formation of therapeutic physician-patient relationships are assessed through the use of Simulated Patient (SP) encounters. The physician-participant

conducts patient interviews in an exam-room setting. The patient cases are selected based on the physician-participant's specialty area. Both the SPs and the physician-participant evaluate the interaction. The patient encounters are videotaped and analyzed by a communication consultant. The consultant provides the physician-participant with feedback.

Patient Care Documentation

Physician-participants are asked to submit redacted copies of patient charts. The charts are reviewed for documentation legibility, content, consistency and accuracy. The physician's attention to pertinent medical details is noted.

Review of Documentation – Simulated Patient Encounter Progress Notes

Following the Simulated Patient (SP) encounters, the physician-participant is asked to document each interaction in a chart note.

Cognitive Function Screen

MicroCog™, a computer-based assessment of cognitive skills, is a screening test to help determine which physician-participants should be given a complete neuropsychological work-up. The test is viewed as a *screening instrument only* and is not diagnostic.

This screening test does not require proficiency with computers; a proctor is available to answer questions about test instructions. Test performance or expected test performance can be impacted by a number of factors, including normal aging and background. A neuropsychologist analyzes the test results, taking these factors into account.

Review of Health Information

The physician-participant is asked to submit the findings from a recent physical examination as well as hearing and vision screens. If indicated, program staff requests information related to specific health concerns.